FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044271

Facility Name: GRASMERE PLACE

Address: 4621 N SHERIDAN RD (Number) CHICAGO (City) 60640 (Zip Code)

County: COOK

Telephone Number: (773) 334-6601 **Fax #** (773) 334-3619

IDPA ID Number: 364269374001

Date of Initial License for Current Owners: 02/01/99

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) EDWARD N. SLACK, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	216	Intermediate (ICF)	216	78,840	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	216	TOTALS	216	78,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	72,918	320		73,238	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	72,918	320		73,238	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.89%

D. How many bed-hold days during this year were paid by Public Aid?
3394 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/99

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/99 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	168,761	27,475	17,804	214,040		214,040	(2,061)	211,979			1
2	Food Purchase		246,563		246,563	(33,635)	212,928	(600)	212,328			2
3	Housekeeping	191,687	34,744		226,431		226,431	2,278	228,709			3
4	Laundry		12,829	16,753	29,582		29,582		29,582			4
5	Heat and Other Utilities			139,756	139,756		139,756	(1,449)	138,307			5
6	Maintenance	100,734		115,360	216,094		216,094	16,378	232,472			6
7	Other (specify):*							2,360	2,360			7
8	**TOTAL General Services**	461,182	321,611	289,673	1,072,466	(33,635)	1,038,831	16,906	1,055,738			8
	B. Health Care and Programs											
9	Medical Director			4,575	4,575		4,575	(375)	4,200			9
10	Nursing and Medical Records	928,241	24,618	5,832	958,691		958,691	31,455	990,146			10
10a	Therapy							6,801	6,801			10a
11	Activities	214,376	12,567	5,729	232,672		232,672	(1,128)	231,544			11
12	Social Services	392,363	6,695	17,553	416,611		416,611	2,184	418,795			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							5,852	5,852			15
16	**TOTAL Health Care and Programs**	1,534,980	43,880	33,689	1,612,549		1,612,549	44,788	1,657,337			16
	C. General Administration											
17	Administrative			288,686	288,686		288,686	(64,038)	224,648			17
18	Directors Fees											18
19	Professional Services			347,051	347,051	(11,558)	335,493	(290,503)	44,990			19
20	Dues, Fees, Subscriptions & Promotions			72,664	72,664		72,664	(39,174)	33,490			20
21	Clerical & General Office Expenses	190,821	14,923	148,921	354,665		354,665	(3,685)	350,980			21
22	Employee Benefits & Payroll Taxes			389,248	389,248	33,635	422,883	(21,138)	401,745			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,078	3,078		3,078	1,594	4,672			24
25	Other Admin. Staff Transportation			9,389	9,389		9,389	(7,447)	1,942			25
26	Insurance-Prop.Liab.Malpractice			36,652	36,652		36,652	1,541	38,193			26
27	Other (specify):*							34,732	34,732			27
28	**TOTAL General Administration**	190,821	14,923	1,295,689	1,501,433	22,077	1,523,510	(388,117)	1,135,392			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,186,983	380,414	1,619,051	4,186,448	(11,558)	4,174,890	(326,423)	3,848,467			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GRASMERE PLACE #0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			33,679	33,679		33,679	319,573	353,252			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			264	264		264	744,872	745,136			32
33	Real Estate Taxes			116,842	116,842	11,558	128,400	4,378	132,778			33
34	Rent-Facility & Grounds			914,544	914,544		914,544	(908,535)	6,009			34
35	Rent-Equipment & Vehicles			17,592	17,592		17,592	4,525	22,117			35
36	Other (specify):*							143,274	143,274			36
37	**TOTAL Ownership**			1,082,921	1,082,921	11,558	1,094,479	308,087	1,402,566			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,260	118,260		118,260		118,260			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			118,260	118,260		118,260		118,260			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,186,983	380,414	2,820,232	5,387,629		5,387,629	(18,336)	5,369,293			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(88,016)	30		9
10	Interest and Other Investment Income	(54,858)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(11)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(63,745)	21		24
25	Fund Raising, Advertising and Promotional	(17,196)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(5,896)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(190,443)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (420,665)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	402,329		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 402,329		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (18,336)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

GRASMERE PLACE

ID# 0044271

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	NON ALLOWABLE ACCOUNTING FEES	$ (10,845)	19	1
2	LLC FEE	(225)	20	2
3	PPA - OFFICE	(58,386)	21	3
4	PPA - EMP BENEFITS	(2,020)	22	4
5	PPA- MED DIR	(375)	09	5
6	PPA - GAS	(4,466)	05	6
7	PPA - SALES TAX	(42)	02	7
8	PPA - INSURANCE	(4)	26	8
9	BANK CHARGES	(5,382)	21	9
10	THEFT LOSS	(1,060)	21	10
11	ADJUSTMENT TO JURY DUTY INCOME	(103)	10	11
12	NON ALLOWABLE LEGAL	(612)	19	12
13	IL COUNCIL COPE	(3,959)	20	13
14	MANAGEMENT FEES	(100,000)	17	14
15	BANK CHARGES - BLDG. PARTNERSHIP	(2)	21	15
16	TRUST FEES - BLDG. PARTNERSHIP	(200)	20	16
17	BUS	(2,762)	25	17
18				18
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98				98
99				99
100				100
	Total	(190,443)		

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			5,823	(7,884)								(2,061)	1
2	Food Purchase	(53)		(547)									(600)	2
3	Housekeeping			2,278									2,278	3
4	Laundry													4
5	Heat and Other Utilities	(4,466)		3,017									(1,449)	5
6	Maintenance			16,717	(339)								16,378	6
7	Other (specify):*			2,360									2,360	7
8	**TOTAL General Services**	(4,519)		29,648	(8,223)								16,906	8
	B. Health Care and Programs													
9	Medical Director	(375)											(375)	9
10	Nursing and Medical Records	(103)		34,115			(2,557)						31,455	10
10a	Therapy			6,801									6,801	10a
11	Activities			2,634	(3,762)								(1,128)	11
12	Social Services			2,477	(293)								2,184	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			5,852									5,852	15
16	**TOTAL Health Care and Programs**	(478)		51,879	(4,056)		(2,557)						44,788	16
	C. General Administration													
17	Administrative	(100,000)		54,867	(96,486)	77,581							(64,038)	17
18	Directors Fees													18
19	Professional Services	(11,457)	10,845	8,042	(297,933)								(290,503)	19
20	Fees, Subscriptions & Promotions	(22,080)	425	2,191	(19,710)								(39,174)	20
21	Clerical & General Office Expenses	(134,471)	2	157,355	(26,571)								(3,685)	21
22	Employee Benefits & Payroll Taxes	(2,020)			(19,118)								(21,138)	22
23	Inservice Training & Education													23
24	Travel and Seminar			1,594									1,594	24
25	Other Admin. Staff Transportation	(2,762)		86	(4,771)								(7,447)	25
26	Insurance-Prop.Liab.Malpractice	(4)		1,545									1,541	26
27	Other (specify):*			23,853		10,879							34,732	27
28	**TOTAL General Administration**	(272,794)	11,272	249,533	(464,588)	88,460							(388,117)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(277,791)	11,272	331,060	(476,867)	88,460	(2,557)						(326,423)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GRASMERE PLACE # 0044271 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(88,016)	395,775	11,814									319,573	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(54,858)	787,366	12,364									744,872	32
33	Real Estate Taxes			4,378									4,378	33
34	Rent-Facility & Grounds		(914,544)	6,009									(908,535)	34
35	Rent-Equipment & Vehicles			4,525									4,525	35
36	Other (specify):*		143,274										143,274	36
37	**TOTAL Ownership**	(142,874)	411,871	39,090									308,087	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(420,665)	423,143	370,150	(476,867)	88,460	(2,557)						(18,336)	45

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				GRASMERE REAL ESTATE, LLC.		
						BUILDING CO.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 914,544	GRASMERE REAL ESTATE, LLC		$	$ (914,544)	1
2	V	32	INTEREST INCOME	14,345	GRASMERE REAL ESTATE, LLC			(14,345)	2
3	V	32	FORGIVNESS OF DEBT	10,001	GRASMERE REAL ESTATE, LLC			(10,001)	3
4	V	32	INTEREST EXPENSE- MORT		GRASMERE REAL ESTATE, LLC		811,712	811,712	4
5	V	19	ACCOUNTING FEES		GRASMERE REAL ESTATE, LLC		10,845	10,845	5
6	V	21	BANK CHARGES		GRASMERE REAL ESTATE, LLC		2	2	6
7	V	20	TRUST FEES		GRASMERE REAL ESTATE, LLC		200	200	7
8	V	36	AMORTIZATION		GRASMERE REAL ESTATE, LLC		67,920	67,920	8
9	V	30	DEPRECIATION		GRASMERE REAL ESTATE, LLC		395,775	395,775	9
10	V	36	M/P INSURANCE EXPENSE		GRASMERE REAL ESTATE, LLC		75,354	75,354	10
11	V	20	LLC FEE		GRASMERE REAL ESTATE, LLC		225	225	11
12	V								12
13	V								13
14	Total			$ 938,890			$ 1,362,033	$ * 423,143	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 5,823	$ 5,823	15
16	V	2	FOOD		CARE CENTERS, INC.	100.00%	(547)	(547)	16
17	V	3	HOUSEKEEPING		CARE CENTERS, INC.	100.00%	2,278	2,278	17
18	V	5	UTILITIES		CARE CENTERS, INC.	100.00%	3,017	3,017	18
19	V	6	REPAIRS AND MAINT.		CARE CENTERS, INC.	100.00%	16,717	16,717	19
20	V	7	EMP. BEN. - GEN. SERV.		CARE CENTERS, INC.	100.00%	2,360	2,360	20
21	V	10	NURSING		CARE CENTERS, INC.	100.00%	34,115	34,115	21
22	V	10A	THERAPY		CARE CENTERS, INC.	100.00%	6,801	6,801	22
23	V	11	ACTIVITIES		CARE CENTERS, INC.	100.00%	2,634	2,634	23
24	V	12	SOCIAL SERVICES		CARE CENTERS, INC.	100.00%	2,477	2,477	24
25	V	15	EMP. BEN. - HEALTHCARE		CARE CENTERS, INC.	100.00%	5,852	5,852	25
26	V	17	ADMINISTRATIVE		CARE CENTERS, INC.	100.00%	54,867	54,867	26
27	V	19	PROFESSIONAL FEES		CARE CENTERS, INC.	100.00%	8,042	8,042	27
28	V	20	DUES, SUBSCRIPTIONS		CARE CENTERS, INC.	100.00%	2,191	2,191	28
29	V	21	CLERICAL AND GENERAL		CARE CENTERS, INC.	100.00%	157,355	157,355	29
30	V	24	SEMINARS		CARE CENTERS, INC.	100.00%	1,594	1,594	30
31	V	25	AUTO EXPENSE		CARE CENTERS, INC.	100.00%	86	86	31
32	V	26	INSURANCE		CARE CENTERS, INC.	100.00%	1,545	1,545	32
33	V	27	EMP. BEN. - GEN. ADMIN.		CARE CENTERS, INC.	100.00%	23,853	23,853	33
34	V	30	DEPRECIATION		CARE CENTERS, INC.	100.00%	11,814	11,814	34
35	V	32	INTEREST		CARE CENTERS, INC.	100.00%	12,364	12,364	35
36	V	33	REAL ESTATE TAXES		CARE CENTERS, INC.	100.00%	4,378	4,378	36
37	V	34	BUILDING RENT - UNRELATED		CARE CENTERS, INC.	100.00%	6,009	6,009	37
38	V	35	EQUIPMENT RENTAL		CARE CENTERS, INC.	100.00%	4,525	4,525	38
39	Total			$			$ 370,150	$ * 370,150	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 7,884	CARE CENTERS, INC.	100.00%	$	$ (7,884)	15
16	V	19	ACCOUNTING	15,000	CARE CENTERS, INC.	100.00%		(15,000)	16
17	V	19	ANCIL ADMIN FEE	25,920	CARE CENTERS, INC.	100.00%		(25,920)	17
18	V	19	BOOKEEPING	44,064	CARE CENTERS, INC.	100.00%		(44,064)	18
19	V	19	DATA PROCESSING	7,776	CARE CENTERS, INC.	100.00%		(7,776)	19
20	V	19	LEGAL	19,710	CARE CENTERS, INC.	100.00%		(19,710)	20
21	V	19	MANAGEMENT FEE	181,440	CARE CENTERS, INC.	100.00%		(181,440)	21
22	V	19	PROFESSIONAL FEES	4,023	CARE CENTERS, INC.	100.00%		(4,023)	22
23	V	20	ADVERTISING	19,710	CARE CENTERS, INC.	100.00%		(19,710)	23
24	V	25	REBILL BUS	4,771	CARE CENTERS, INC.	100.00%		(4,771)	24
25	V								25
26	V	22	HOME OFFICE PAYROLL TAX	19,118	CARE CENTERS, INC.	100.00%		(19,118)	26
27	V	1	REBILL. PAYROLL DIETARY		CARE CENTERS, INC.	100.00%			27
28	V	3	REBILL. PAYROLL HSKPNG		CARE CENTERS, INC.	100.00%			28
29	V	6	REBILL. PAYROLL MAINT.	339	CARE CENTERS, INC.	100.00%		(339)	29
30	V	10	REBILL. PAYROLL NURSING		CARE CENTERS, INC.	100.00%			30
31	V	10A	REBILL. PAYROLL THPY CONS.		CARE CENTERS, INC.	100.00%			31
32	V	11	REBILL. PAYROLL ACTIVITIES	3,762	CARE CENTERS, INC.	100.00%		(3,762)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	293	CARE CENTERS, INC.	100.00%		(293)	33
34	V	17	REBILL. PAYROLL ADMIN.	96,486	CARE CENTERS, INC.	100.00%		(96,486)	34
35	V	21	REBILL. PAYROLL CLERICAL	26,571	CARE CENTERS, INC.	100.00%		(26,571)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 476,867			$	$ * (476,867)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$	$	15
16	V	15	EMP. BEN HEALTHCARE		CARE CENTERS, INC.	100.00%			16
17	V	17	ADMINISTRATIVE		CARE CENTERS, INC.	100.00%	77,581	77,581	17
18	V	27	EMP. BEN GEN. ADMIN.		CARE CENTERS, INC.	100.00%	10,879	10,879	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 88,460	$ * 88,460	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICAL SUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 21,053	$ 21,053	15
16	V								16
17	V								17
18	V								18
19	V	10	MEDICAL SUPPLIES	23,610	XCEL MEDICAL SUPPLLY LLC	100.00%		(23,610)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 23,610			$ 21,053	$ * (2,557)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 130,980	$ 130,980	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	130,980	CCS EMPLOYEE BENEFIT GROUP	100.00%		(130,980)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 130,980			$ 130,980	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ERIC ROTHNER	RELATIVE	Administrative	0%	SEE ATTACHED	2.36	3.28%	Mgt. Fee	$ 80,000	17-3	1
2	MARK STEINBERG	RELATIVE	Administrative	0%	SEE ATTACHED	2.41	4.82%	Alloc Salary	2,137	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 82,137		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,522,375	33	$ 121,047	$ 120,871	73,238	$ 5,823	1
2	2	FOOD	PATIENT DAYS	1,522,375	33	(11,374)		73,238	(547)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,522,375	33	47,342	43,569	73,238	2,278	3
4	5	UTILITIES	PATIENT DAYS	1,522,375	33	62,714		73,238	3,017	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,522,375	33	347,481	212,397	73,238	16,717	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,522,375	33	49,052		73,238	2,360	6
7	10	NURSING	PATIENT DAYS	1,522,375	33	709,129	712,466	73,238	34,115	7
8	10A	THERAPY	PATIENT DAYS	1,522,375	33	141,364	140,790	73,238	6,801	8
9	11	ACTIVITIES	PATIENT DAYS	1,522,375	33	54,745	53,877	73,238	2,634	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,522,375	33	51,491	51,491	73,238	2,477	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,522,375	33	121,645		73,238	5,852	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,522,375	33	1,140,506	1,135,183	73,238	54,867	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,522,375	33	167,175		73,238	8,042	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,522,375	33	45,541		73,238	2,191	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,522,375	33	3,270,885	2,869,864	73,238	157,355	15
16	24	SEMINARS	PATIENT DAYS	1,522,375	33	33,128		73,238	1,594	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,522,375	33	1,780		73,238	86	17
18	26	INSURANCE	PATIENT DAYS	1,522,375	33	32,120		73,238	1,545	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,522,375	33	495,816		73,238	23,853	19
20	30	DEPRECIATION	PATIENT DAYS	1,522,375	33	245,564		73,238	11,814	20
21	32	INTEREST	PATIENT DAYS	1,522,375	33	257,009		73,238	12,364	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,522,375	33	91,002		73,238	4,378	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,522,375	33	124,898		73,238	6,009	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,522,375	33	94,062		73,238	4,525	24
25	TOTALS					$ 7,694,122	$ 5,340,509		$ 370,150	25

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		7	384,296	384,296			1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		7	49,011				2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		27	1,367,742	1,367,742		77,581	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		27	180,242			10,879	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,981,291	$ 1,752,038		$ 88,460	25

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICAL SUPPLIES	DIRECT ALLOCATION			$	$		$ 21,053	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 21,053	25

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 130,980	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 130,980	25

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	BUILDING PARNERSHIP	X		MORTGAGE	$71,078	01/26/99	$ 9,518,795	$ 9,471,863			$ 811,712	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$71,078		$ 9,518,795	$ 9,471,863			$ 811,712	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(66,576)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (66,576)	14
15	TOTALS (line 9+line14)						$ 9,518,795	$ 9,471,863			$ 745,136	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	ASSURANCE AGENCY		X	INSURANCE	15		$	$			$ 264	1
2	ALLOCATION - CCI	X									12,364	2
3	INTEREST INCOME-BLDG	X									(14,345)	3
4	FORGIVNESS DEBT-BLDG	X									(10,001)	4
5	INTEREST INCOME										(54,858)	5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (66,576)	21

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 107,799	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 118,313	2
3. Under or (over) accrual (line 2 minus line 1).		$ 10,514	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 110,706	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 11,558	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 132,778	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998	106,146	10
1999	105,434	11
2000	113,935	12

2001 ACCRUAL = 1999 RE TAX BILL $105434 X 1.05 = 110706

ALLOCATION CCI = $4378 TOTAL = $118313

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GRASMERE PLACE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0044271

CONTACT PERSON REGARDING THIS REPORT STEVEN LAVENDA

TELEPHONE (847) 236 - 1111 FAX #: (847) 236 - 1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-17-214-001-0000	LTC PROPERTY	$ 110,146.85	$ 110,146.85
2.	14-17-214-002-0000	LTC PROPERTY	$ 1,893.42	$ 1,843.92
3.	14-17-214-003-0000	LTC PROPERTY	$ 1,893.42	$ 1,893.42
4.	SEE ATTACHED	HOME OFFICE ALLOCATION	$ 66,986.83	$ 3,222.58
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 180,920.52	$ 117,106.77

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,000 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 4

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1999	$ 800,000	1
2	ALLOC CCI			3,079	2
3	TOTALS			$ 803,079	3

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		6,018,619	154,376		180,273	25,897	522,145	68
69	Financial Statement Depreciation			9,406			(9,406)		69
70	TOTAL (lines 4 thru 69)		$ 6,018,619	$ 163,782		$ 180,273	$ 16,491	$ 522,145	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 6,018,619	$ 163,782		$ 180,273	$ 16,491	$ 522,145	1
2	HVAC RENOVATION	1999	948			47	47	133	2
3	HVAC RENOVATION	1999	719			36	36	102	3
4	HVAC RENOVATION	1999	1,015			51	51	145	4
5	BOILER	1999	5,719			286	286	739	5
6	BOILER	1999	2,842			142	142	355	6
7	FLOORING	1999	512			26	26	65	7
8	FLOORING	1999	436			22	22	55	8
9	COVE BASE	1999	371			19	19	48	9
10	FLOORING	1999	4,704			235	235	568	10
11	BOILER	1999	875			44	44	99	11
12	KITCHEN WIRING	1999	7,805			390	390	845	12
13	PLUMBING RENOVATION	1999	777			39	39	85	13
14	FLOORING	1999	12,587			629	629	1,363	14
15	PLUMBING	1999	7,000			350	350	729	15
16	RADIATOR RENOV	1999	653			33	33	69	16
17	PAINTING	1999	507			25	25	52	17
18	DRYWALL	1999	8,700			435	435	906	18
19	PLUMBING	1999	939			47	47	98	19
20	SPRINKLERS	1999	899			45	45	94	20
21	EQUIPMENT REPAIR	1999	719			36	36	102	21
22	A/C UNITS	1999	890			45	45	116	22
23	COMPRESSOR	1999	1,695			85	85	220	23
24	WATER HEATER	1999	1,406			70	70	181	24
25	ALARM COVERS	1999	1,150			58	58	150	25
26	COOLER RENOVATION	1999	1,152			58	58	140	26
27	CALL BUTTONS	1999	981			49	49	110	27
28	WATER HEATER	1999	819			41	41	89	28
29	A/C RENOV	1999	750			38	38	79	29
30	BOILER	1999	544			27	27	63	30
31	KITCHEN	1999	15,000			750	750	1,438	31
32	INSTALL TILES	2000	18,700			935	935	1,870	32
33	INSTALL CONCRETE	2000	1,500			75	75	150	33
34	TOTAL (lines 1 thru 33)		$ 6,121,933	$ 163,782		$ 185,441	$ 21,659	$ 533,403	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 6,121,933	$ 163,782		$ 185,441	$ 21,659	$ 533,403	1
2	PLUMBING RENOV	2000	4,630			232	232	464	2
3	INSTALL CARPETING	2000	588			29	29	58	3
4	INSTALL VCT TILE	2000	1,569			78	78	156	4
5	PAINT	2000	1,046			52	52	104	5
6	ELECTRIC RENOV	2000	10,037			502	502	1,004	6
7	INSTALL GREASE TRAP	2000	1,142			57	57	109	7
8	PAINT	2000	1,450			73	73	140	8
9	KITCHEN REMOLDELING	2000	33,147			1,657	1,657	3,176	9
10	BEDSPREADS	2000							10
11	DEADLOCKS	2000	626			31	31	57	11
12	PAINT	2000	4,866			243	243	446	12
13	REFRIGE RENOV	2000	2,200			110	110	202	13
14	STEEL DOORS	2000	3,300			165	165	303	14
15	PLASTER	2000	15,000			750	750	1,313	15
16	PAINT	2000	2,611			261	261	457	16
17	RADIATOR RENOV	2000	1,616			81	81	142	17
18	PLASTER/PAINT	2000	20,000			1,000	1,000	1,667	18
19	PLASTER/PAINT	2000	2,500			125	125	208	19
20	DEPOSIT	2000	17,000			850	850	1,417	20
21	FOOD PROCESSOR	2000							21
22	LANDSCAPING	2000	2,001			100	100	158	22
23	HOT WATER HEATER REP	2000	500			25	25	40	23
24	FRONT DOOR REPAIR	2000	650			33	33	52	24
25	ELECTRIC WIRING	2000	21,450			1,073	1,073	1,699	25
26	CARPETING INSTALL	2000	11,844			592	592	937	26
27	FRONT DOOR REPAIR	2000	675			34	34	51	27
28	ELECTRICAL WIRING	2000	1,923			96	96	128	28
29	PLUMBING REPAIR	2000	653			33	33	41	29
30	ELEVATOR REPAIR	2000	4,476			224	224	280	30
31	ROOF REPAIR	2000	7,220			361	361	451	31
32	FIRE PUMP REPAIR	2000	1,867			93	93	132	32
33	BINDER ELECTRIC	2000	6,332			317	317	449	33
34	TOTAL (lines 1 thru 33)		$ 6,304,852	$ 163,782		$ 194,718	$ 30,936	$ 549,244	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 6,304,852	$ 163,782		$ 194,718	$ 30,936	$ 549,244	1
2	FURNITURE FOR PARK	2000	12,695			635	635	900	2
3	INSTALLN OF BSKTBL S	2000	2,304			115	115	163	3
4	NURSING STATION CBNT	2000	7,065			353	353	412	4
5	COOLER RENOV	2000	3,052			153	153	179	5
6	FIRE ALARM	2000	3,169			158	158	184	6
7	PLUMBING SUPPLIES	2000	980			49	49	57	7
8	ALARM CLOCK	2000							8
9	FIRE ALARM REPAIR	2000	2,495			125	125	135	9
10	BOILER REPAIR	2000	2,629			131	131	142	10
11	LAVATORY REMODELING	2000	603			30	30	33	11
12	REPLACEMENT PIPING	2000	4,996			250	250	271	12
13	INSTALLATION OF RDTR	2000	1,507			75	75	81	13
14	RADIATOR REPAIR	2000	564			28	28	30	14
15	DRAPES	2000	4,840			242	242	262	15
16	CALL STATION REPAIR	2000	939			47	47	51	16
17	PLUMBING SUPPLIES	2000	980			49	49	53	17
18	PLUMBING	2000	653			33	33	98	18
19	PLUMBING	2000	1,691					85	19
20	WATER HEATER RENOV	2000	1,603						20
21	TOILETS	2000	574						21
22	COOLER RENOV	2000	518						22
23	TOILETS	2000	653						23
24	TOILETS	2000	653						24
25	PLUMBING REPAIR	2000	1,960						25
26	FOOD PROCESSOR	2000	930						26
27	NURSE CALL STATION R	2001	8,231			412	412	412	27
28	LAUNDRY ROOM LEAK RE	2001	4,748			237	237	237	28
29	PIPING REPAIR	2001	532			27	27	27	29
30		2001	600			30	30	30	30
31	NEW RODS DRAPES	2001	765			38	38	38	31
32	HEATING SYSTEM REPAI	2001	2,283			105	105	105	32
33	WATER LEAK REPAIR	2001	1,208			55	55	55	33
34	TOTAL (lines 1 thru 33)		$ 6,381,272	$ 163,782		$ 198,095	$ 34,313	$ 553,284	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 6,381,272	$ 163,782		$ 198,095	$ 34,313	$ 553,284	1
2	HEATING SYSTEM REPAI	2001	536			25	25	25	2
3	FLOOR TILES	2001	2,137			89	89	89	3
4	PLUMBING REPAIR IN M	2001	2,031			85	85	85	4
5	ELECTRICAL SUPPLIES	2001	1,574			66	66	66	5
6	BATHROOM REMODELING	2001	1,000			42	42	42	6
7	BATHROOM REMODELING	2001	1,200			50	50	50	7
8	PAINT	2001	1,351			40	40	40	8
9	LANDSCAPING	2001	2,115			62	62	62	9
10	PLANS FOR ELEC.WORK	2001	660			19	19	19	10
11	AC REPAIR	2001	2,065			52	52	52	11
12	AC REPAIR	2001	510			13	13	13	12
13	BOILER REPAIR	2001	3,279			68	68	68	13
14	PLUMBING REPAIR-KITC	2001	1,886			39	39	39	14
15	BOILER ROOM REPAIR	2001	2,160			45	45	45	15
16	SLIDING GATE	2001	1,840			38	38	38	16
17	FIREBRICK BACKUP SYS	2001	2,297			38	38	38	17
18	TILES	2001	841			14	14	14	18
19	PLUMBING REPAIR	2001	1,057			13	13	13	19
20	CARPETING	2001	6,145			51	51	51	20
21	TILES	2001	634			5	5	5	21
22	PLUMBING REPAIR	2001	4,000			33	33	33	22
23	PLUMBING REPAIR	2001	2,052			17	17	17	23
24	SPRINKLER SYSTEM REP	2001	1,750			15	15	15	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,424,392	$ 163,782		$ 199,014	$ 35,232	$ 554,203	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 6,424,392	$ 163,782		$ 199,014	$ 35,232	$ 554,203	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,424,392	$ 163,782		$ 199,014	$ 35,232	$ 554,203	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 6,424,392	$ 163,782		$ 199,014	$ 35,232	$ 554,203	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,424,392	$ 163,782		$ 199,014	$ 35,232	$ 554,203	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 6,424,392	$ 163,782		$ 199,014	$ 35,232	$ 554,203	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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17									17
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,424,392	$ 163,782		$ 199,014	$ 35,232	$ 554,203	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 6,424,392	$ 163,782		$ 199,014	$ 35,232	$ 554,203	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 6,424,392	$ 163,782		$ 199,014	$ 35,232	$ 554,203	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	216		1999		$ 5,578,000	$ 143,026	35	$ 159,371	$ 16,345	$ 464,832	4
5			1996		54,488	1,397	35	1,557	160	7,914	5
6											6
7											7
8											8
	Improvement Type**										
9	CARE CENTERS ALLOCATION			2001	155	20	20	4	(16)	4	9
10	CARE CENTERS ALLOCATION			2000	66	2	20	3	1	6	10
11	CARE CENTERS ALLOCATION			1999	976	25	20	49	24	141	11
12	CARE CENTERS ALLOCATION			1998	403	10	20	20	(10)	74	12
13	CARE CENTERS ALLOCATION			1997	5,715	101	20	315	214	1,843	13
14	CARE CENTERS ALLOCATION			1996	6,282	83	20	331	248	1,301	14
15	CARE CENTERS ALLOCATION			1994		18	20		(18)		15
16	CARE CENTERS ALLOCATION			1993		6	10		(6)		16
17	CARE CENTERS ALLOCATION			1997	663	154	20	28	(126)	93	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	GRASMERE REAL ESTATE , LLC	1999	$ 192,580	$ 4,938	20	$ 9,629	$ 4,691	$ 25,677	37
38	GRASMERE REAL ESTATE , LLC	1999	19,311	495	20	966	471	2,415	38
39	GRASMERE REAL ESTATE , LLC	1999	1,573	40	20	79	39	191	39
40	GRASMERE REAL ESTATE , LLC	1999	50,131	1,285	20	2,507	1,222	5,850	40
41	GRASMERE REAL ESTATE , LLC	1999	17,558	450	20	878	428	1,976	41
42	GRASMERE REAL ESTATE , LLC	1999	90,718	2,326	20	4,536	2,210	9,828	42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,018,619	$ 154,376		$ 180,273	$ 25,877	$ 522,145	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,465,810	$ 263,197	$ 146,815	$ (116,382)	10	$ 417,229	71
72	Current Year Purchases	40,256	8,600	3,174	(5,426)	10	3,174	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 1,506,066	$ 271,797	$ 149,989	$ (121,808)		$ 420,403	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		ESCORT	2001	$ 8,270	$ 1,654	$ 207	$ (1,447)	5	$ 207	76
77	CCI ALLOCATION			26,348	4,032	4,039	7	5	13,000	77
78										78
79										79
80	TOTALS			$ 34,618	$ 5,686	$ 4,246	$ (1,440)		$ 13,207	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	8,768,155	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	441,265	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	353,249	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(88,016)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	987,813	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	ALLOC CCI				6,009			5
6								6
7	TOTAL				$ 6,009 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 17,253 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATOR		$ 405.40	$ 4,865	17
18					18
19					19
20					20
21	TOTAL		$	$ 4,865	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 45,879	$ 53,354	1
2	Cash-Patient Deposits	16,986	16,986	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	816,400	816,400	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	17,450	61,598	6
7	Other Prepaid Expenses	32,406	32,406	7
8	Accounts Receivable (owners or related parties)	1,365,099	1,365,099	8
9	Other(specify): See supplemental schedule	86,295	707,994	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,380,515	$ 3,053,837	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		800,000	13
14	Buildings, at Historical Cost		5,578,000	14
15	Leasehold Improvements, at Historical Cost	391,424	763,294	15
16	Equipment, at Historical Cost	105,928	1,477,261	16
17	Accumulated Depreciation (book methods)	(58,369)	(1,256,419)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	47,500	957,169	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 486,483	$ 8,319,305	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,866,998	$ 11,373,142	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 373,310	$ 373,311	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,211	10,211	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	160,547	160,547	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,328	4,328	31
32	Accrued Real Estate Taxes(Sch.IX-B)	110,706	110,706	32
33	Accrued Interest Payable		67,487	33
34	Deferred Compensation	1,258	1,258	34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 660,360	$ 727,848	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,471,863	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 9,471,863	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 660,360	$ 10,199,711	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,206,638	$ 1,173,431	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,866,998	$ 11,373,142	48

*(See instructions.)

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,319,950	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,319,950	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	1,426,688	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(540,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 886,688	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,206,638	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,759,356	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,759,356	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	54,858	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 54,858	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	103	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 103	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,814,317	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,072,466	31
32	Health Care	1,612,549	32
33	General Administration	1,501,433	33
	B. Capital Expense		
34	Ownership	1,082,921	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	118,260	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,387,629	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,426,688	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,426,688	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,043	2,245	$ 58,455	$ 26.04	1
2	Assistant Director of Nursing	2,085	2,291	53,342	23.28	2
3	Registered Nurses	567	623	12,929	20.76	3
4	Licensed Practical Nurses	17,963	19,739	312,277	15.82	4
5	Nurse Aides & Orderlies	56,902	62,529	473,973	7.58	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,681	2,946	37,384	12.69	9
10	Activity Assistants	16,812	18,475	176,992	9.58	10
11	Social Service Workers	23,756	26,105	392,363	15.03	11
12	Dietician					12
13	Food Service Supervisor	2,842	3,124	50,195	16.07	13
14	Head Cook	6,069	6,669	59,892	8.98	14
15	Cook Helpers/Assistants	7,541	8,287	58,674	7.08	15
16	Dishwashers					16
17	Maintenance Workers	6,765	7,434	100,734	13.55	17
18	Housekeepers	28,785	31,632	191,687	6.06	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	13,556	14,896	190,821	12.81	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,275	1,401	17,265	12.32	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	189,642	208,398	$ 2,186,983 *	$ 10.49	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	$ 17,804	01-03	35
36	Medical Director	monthly	4,575	09-03	36
37	Medical Records Consultant	monthly	4,032	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	1,800	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	46	1,967	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	ART THERAPIST	432	17,260	12-03	47
48	CCI COSTS - SEE ATTACHED		4,055	VARIOUS	48
49	TOTAL (lines 35 - 48)	478	$ 51,493		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ADMINISTRATIVE SALARIES			$
DIRECTLY ALLOCATED FROM			
HOME OFFICE SEE P. 6B			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
CHRIS WAYER - MGMT FEES	$ 200
ERIC ROTHNER - MGMT FEES	180,000
NATHAN LANGNER - MGMT FEES	12,000
CCI ADMINISTRATIVE PAYROLL (ADJUSTED ON P.6B)	96,486
TOTAL (agree to Schedule V, line 17, col. 3)	$ 288,686
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
SEE ATTACHED	LEGAL	$ 32,593
FR&R	ACCOUNTING	19,540
CARE CENTERS	ACCOUNTING	15,000
LEGAT ARCHITECTS	ARCHITECT FEE	550
PERSONNEL PLANNERS	UNEMPLOYMENT CONS.	4,724
CARE CENTERS	PROF. FEES	3,015
CARE CENTERS	TAX SERVICES	1,008
CARE CENTERS	ANCILLARY ADMIN SRVS	25,920
CARE CENTERS	BOOKKEEPING	44,064
SEE ATTACHED	DATA PROCESSING	19,197
CARE CENTERS	HOME OFFICE EXPENSE	181,440
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 347,051

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 32,745
Unemployment Compensation Insurance	30,512
FICA Taxes	167,304
Employee Health Insurance	112,712
Employee Meals	33,635
Illinois Municipal Retirement Fund (IMRF)*	
CHICAGO EMP TAX	3,816
PENSION EXPENSE	16,158
EMPL PHYS	2,328
MISC EMP WELFARE	2,091
CHRISTMAS EXP.	444
TOTAL (agree to Schedule V, line 22, col.8)	$ 401,745

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	14,305
Health Care Worker Background Check	
(Indicate # of checks performed 303)	3,354
DUES	9,817
LICENSE	3,423
ADVERTISING	17,196
ALLOC CCI	2,191
Less: Public Relations Expense	
Non-allowable advertising	(17,196)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,490

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,078
ALLOC CCI	1,594
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,672

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
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8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number GRASMERE PLACE # 0044271 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL $8744**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **NONE** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **118,260**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **33,635** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%ln14**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **NONE**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees